

APPENDIX G

THE GENEVA CONVENTIONS**G-1. Law of Land Warfare***a. Sources of the Law of Land Warfare.*

(1) The Law of Land Warfare is drawn from two sources:

(a) The first is treaty law. Treaties are formally enacted under procedures set out in the US Constitution. They are laws of the highest order and statutes and regulations must comply with them. They govern all US soldiers and civilians.

(b) The second source of Law of Land Warfare is customary international law. Once a practice is internationally accepted, either by widespread treaty enactment or other agreement, it becomes customary international law. Once this occurs, it regulates even countries which do not agree with the concept concerned.

(2) In the area of CHS, the principal treaties are the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (12 August 1949) and the Hague Resolutions. These are found in DA Pam 27-1. For the commander, FM 27-10 is a handbook reference which will provide the answers to questions concerning the law of war.

b. Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces. This Convention provides for the protection of Armed Forces members and other persons who are wounded and sick on the battlefield. It provides for members of the conflict to take all possible measures to search for and collect the wounded and sick; to protect them against pillage and ill treatment; to ensure their adequate care; and to search for the dead and prevent their being despoiled. It further provides for the protection afforded AMEDD personnel.

G-2. Medical Implications of Geneva Conventions

a. Provisions for Collection of Wounded and Sick. Provisions must be made for the collection and treatment of wounded and sick personnel, whether friend or foe, military or civilian, regardless of legal status. Only urgent medical reasons will determine priority in the order of treatment to be administered. This means that wounded enemy soldiers may be treated before wounded Americans or allies. For enemy personnel wounded as a result of military operations, dual responsibilities must be carried out—custodial and medical. The custodial activity of guarding the wounded EPW should be carried out by assets other than AMEDD personnel. The echelon commander will designate nonmedical units to act as guards when EPW are in medical channels.

b. Accountability and Custody of Enemy Prisoners of War (Geneva Convention Relative to the Treatment of Prisoners of War, 12 August 1949). Enemy prisoners of war evacuated through medical channels must be identified and their accountability established prior to evacuation per appropriate TSOP. Sick, injured, and wounded prisoners may be evacuated through normal medical channels, but they are

segregated from US and allied personnel. They may also be evacuated through dedicated or task organized evacuation assets, particularly in rear areas where they are likely to be moved in a group.

c. Responsibility and Handling of Prisoners of War. The US Army is responsible for the care and treatment of EPW from the moment of capture. Below brigade level, these prisoners are handled by combat troops who bring them to the forward or brigade collecting points. Enemy prisoner of war patients will be evacuated from the CZ as soon as possible. Only those sick or wounded prisoners who would run a greater health risk by being immediately evacuated may be temporarily kept in the CZ. When intelligence sources indicate that large numbers of enemy prisoners may result from an operation, medical units may require reinforcement to support the additional EPW patient work load. In this case, the care of the EPW wounded becomes a joint matter between the ground combat commander and the medical commander. Procedures for estimating the medical work load involved in the treatment and care of enemy prisoners is described in FM 8-55. For a more detailed discussion on the administration, handling, treatment, and identification of EPW, see AR 190-8, FM 8-10, and FM 19-40.

d. Identification and Protection of Medical Personnel.

(1) Personnel exclusively engaged in the performance of medical duties in connection with the sick or wounded in medical units or establishments shall wear, affixed to the left arm, a water-resistant brassard/arm band bearing the distinctive emblem (the red cross on a white background) prescribed by the Geneva Conventions. The wearing of brassards/armbands will be at the discretion of the tactical commander in far forward areas.

(2) Medical personnel are to carry a special identity card, DD Form 1934 (Geneva Conventions Identity Card for Medical and Religious Personnel Who Serve in or Accompany the Armed Forces), issued to all persons qualifying as protected medical personnel (see AR 640-3). It will be carried in addition to their regular identification card.

(3) Enemy military medical personnel who are captured are considered retained personnel and not prisoners of war. They will receive the benefits and protection of the Geneva Conventions and may be required to treat prisoners of war. United States medical personnel or medical units that are captured would do likewise, continuing to provide medical support behind enemy lines. In such a situation, this would probably be a primary source of treatment for US prisoners of war, although enemy wounded could be treated also.

(4) Enemy civilian medical personnel who are physicians, surgeons, dentists, nurses, or medical orderlies may also be required to use their medical knowledge in the interest of prisoners of war. These medical personnel are considered protected (under the Conventions) and receive the same treatment as retained military medical personnel.

(5) Personnel protected as medical personnel under the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field must be *exclusively engaged* in medical duties or administration of medical units. This includes all members of a medical unit, even cooks, mechanics, drivers, or administration personnel. However, this protection is given only if the soldier is exclusively engaged in medical duties. Performance of any nonmedical duty removes the protection, and

the DD 1934 must be withdrawn. For example, if an ambulance driver is tasked with driving an unmarked vehicle forward with ammunition prior to evacuating casualties rearward, he would not be exclusively engaged in medical duties and could not be considered or credentialed as “medical personnel.”

e. Self-Defense.

(1) Medical personnel may carry arms for defense of themselves and their patients. This does not mean that they may resist capture or fire on the advancing enemy. It means that, if the enemy is attacking and ignoring the marked medical status of the medic or the medical unit, the medic may provide self-protection. If the enemy merely seeks to assume control of a medical facility or a vehicle without firing on it, the facility or vehicle may be occupied. Of course, it is preferable and proper to attempt to avoid capture by withdrawal.

(2) The arms that medics may use are only defensive arms. By AR these are defined as service rifles (M-16s) and pistols. Other US services restrict arms to pistols alone.

(3) An overall defense plan may not require medical units to take offensive action against enemy troops at any time. If a medical force is part of a defensive area containing nonmedical units, the medical unit’s personnel (that is, all personnel assigned or attached to that unit) may not be responsible for manning part of the overall perimeter. If located in isolation, the medical unit may provide its own security if other support is not available. However, a medical unit may not be defended from capture even if military police or other soldiers are acting as pickets.

(4) If medical personnel fire on enemy troops or otherwise abuse their protected status, they may lose their special status under the Law of Land Warfare. It is also possible that such a violation could result in a war crimes trial by the capturing force. For instance, if an enemy force was advancing on a marked medical facility but was not firing on it and medical personnel then took advantage of the situation and fired on the enemy, this would be an offense. Under the Law of Land Warfare, this action would constitute an act of perfidy or treason. It would be akin to firing on soldiers exposed under a flag of truce.

This paragraph implements STANAG 2931.

f. Marking of Medical Units/Facilities and Ambulances.

(1) *Medical units and facilities.*

(a) The distinctive flag (red cross on a white background) of the Conventions shall be hoisted only over such medical units and facilities (except veterinary) as are entitled to be respected under the Conventions and only with the consent of the tactical commander of a brigade-size or larger unit. The marking of facilities and the use of camouflage are incompatible and should not be attempted concurrently. Use of the red cross is authorized. The camouflage of medical units is regulated by ARs and also, in the

European theater, by NATO STANAG 2931. It is not envisioned that fixed, large medical facilities would be camouflaged. The commander must be aware of who has the authority to order camouflage and for what period it may last. The camouflage of medical facilities is one of the more difficult ones to reconcile with operational necessities. The problem has been present in past wars but is now more critical due to the ability of intelligence assets to see deep into the rear AO. If the failure to camouflage endangers or compromises the tactical operations, the camouflage of medical facilities may be ordered by a NATO commander of at least brigade level or equivalent. Such an order is to be temporary and local in nature and is countermanded as soon as circumstances permit.

(b) The camouflage of a medical unit does not deprive it of protection. However, the enemy is not required to respect a camouflaged facility until he recognizes it as such, so the protection is illusory to a point, especially where indirect fire weapons are involved. The use of defensive arms by medical personnel at a camouflaged site attacked by ground maneuver forces poses a dilemma. The medics should attempt to make the attackers aware of their status rather than fighting back. However, that may be difficult to do on the modern battlefield.

(c) If medical facilities are used to commit acts harmful to the enemy, the protection of those facilities may be withdrawn if the acts are not stopped after warning. This might be the case where a facility is used as an observation post or if combat information was reported or relayed through the facility.

(2) *Ambulances.*

(a) Air and ground ambulances will be marked with the distinctive red cross emblem. There is no legal reason why the ambulances could not have the red cross removed and then be used for nonmedical roles. It should be remembered that the aviators and drivers may not do nonmedical tasks without losing their medical status. As such, the policy that benefits the mission to the greatest degree is to use ambulances exclusively for medical tasks.

(b) The US policy is that crew-served weapons may not be mounted on armored ambulances or air ambulances, even if mounting brackets are present.

(c) Vehicles other than ambulances may be used in a dual role, moving wounded to the rear under removable red crosses. However, the red crosses must be removed before nonmedical tasks are attempted, and care must be taken so that the protection provided by the red cross is not abused.

g. *Civilians—Wounded and Sick (Geneva Convention Relative to the Protection of Civilian Persons in Time of War, 12 August 1949).* Civilians who are wounded or become sick as a result of military operations will be collected and provided initial medical treatment in accordance with theater policies and transferred to appropriate civil authorities as soon as possible. All those wounded and sick as a result of an armed conflict will be collected and cared for. The echelon commander and medical unit commanders jointly exercise responsibilities for custody and treatment of the sick, injured, or wounded and detained civilian personnel.

h. *Captured Medical Supplies and Equipment.* Because medical supplies and equipment captured from the enemy are considered neutral and protected, they are not to be intentionally destroyed. If these

items are considered unfit for use, or if they are not needed for US and allied forces, noncombatants, or EPW patients, they may be abandoned for enemy use. Since captured medical personnel are familiar with their medical supplies and equipment, the captured items are especially valuable in the treatment of EPW. Use of these captured items for EPW and the indigenous population helps to conserve other medical supplies and equipment. When the capture of US medical supplies and equipment by enemy forces is imminent, these items are not to be purposely destroyed. Every attempt must be made to evacuate them. Those items which cannot be evacuated should be abandoned; however, such abandonment is a command decision.

G-3. Compliance with the Geneva Conventions

a. As the US is a signatory to the Geneva Conventions, all medical personnel should thoroughly understand the provisions that apply to CHS activities. Violation of these Conventions can result in the loss of the protection afforded by them. Medical personnel should inform the tactical commander of the consequences of violating the provisions of these Conventions.

b. Outright violations of the Geneva Conventions result when—

- Medical personnel are used to man or help man the perimeter of nonmedical facilities, such as unit trains, logistics areas, or base clusters.
- Medical personnel are used to man any offensive-type weapons or weapons systems.
- Medical personnel are ordered to engage enemy forces other than in self-defense or in the defense of patients and MTFs.
- Crew-served weapons are mounted on a medical vehicle.
- Mines or booby traps are placed in and around medical units and facilities.
- Hand grenades, light antitank weapons, grenade launchers, or any weapons other than rifles and pistols are issued to a medical unit or its personnel.
- The site of a medical unit is used as an observation post, a fuel dump, or an ammunition storage site.

c. Possible consequences of violations described in *b* above are—

- Loss of protected status for the medical unit and personnel.
- Medical facilities attacked and destroyed by the enemy.
- Medical personnel being considered prisoners of war rather than retained persons when captured.

- Combat health support capabilities are decremented.
- d.* Other examples of violations of the Geneva Conventions include—
- Making medical treatment decisions for the wounded and sick on any basis other than medical priority, urgency, or severity of wounds.
 - Allowing the interrogation of enemy wounded or sick even though medically contraindicated.
 - Allowing anyone to kill, torture, mistreat, or in anyway harm a wounded or sick enemy soldier.
 - Marking nonmedical unit facilities and vehicles with the distinctive emblem or making any other unlawful use of this emblem.
 - Using medical vehicles marked with distinctive Geneva emblem for transporting nonmedical troops, equipment, and supplies.
 - Using a medical vehicle as a TOC.
- e.* Possible consequences of violations described in *d* above are—
- Criminal prosecution for war crimes.
 - Reprisals taken against our wounded in the hands of the enemy.
 - Medical facilities attacked and destroyed by the enemy.
 - Medical personnel being considered prisoners of war rather than retained persons when captured.